WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
Bureau of Eligibility Management
1 West Wilson Street
PO Box 309
Madison WI 53701-0309

TO: Medicaid Eligibility Handbook Holders

FROM: Cheryl McIlquham, Director
Bureau of Eligibility Management

RE: Medicaid Eligibility Handbook Release 05-02

DATE: May 10, 2005

The changes noted in this cover sheet are incorporated into the online handbook. Changes in the MEH are indicated with yellow highlighted text. Anytime you access the online MEH, it will reflect current policy. To be notified of MEH releases by email, go to http://dhfs.wisconsin.gov/em/policy-notification/signup.htm, enter your email address and check the "Medicaid" box in the "notification listing" section.

EFFECTIVE DATE — Release and effective dates are at the bottom of each web page within the MEH.

The following changes are included in this release:

CHANGES

1.2.3.1.1 — Operations Memo 04-43, "Adding a Newborn Child to A Medicaid Case" has been obsoleted. Add a newborn to a Medicaid case if reported by mother or in a letter from EDS. New text was added to reflect this policy.

New Text

The Medicaid fiscal agent, EDS, receives notification of children born to Medicaid recipients from hospitals and HMOs. EDS certifies these newborns as Continuously Eligible Newborns in the Medicaid Management Information System and sends a letter to both the mother of the newborn and to the certifying agency. This newborn letter received from the fiscal agent is a reported change. For purposes of Medicaid, the worker should add the newborn to CARES entering the pseudo SSN based upon the letter received on the CARES screen ANID. No further proof is required.

2.1.3.2

Clarification was made that a recipient in a hospital for 30 or more days is a resident of the county in which the hospital is located.

New Text

The client must apply in the county in which s/he resides. A client who resides in a nursing home/**hospital for 30 days or more and will have their Medicaid eligibility determined as an institutionalized case** is a resident of the county in which the nursing home/**hospital** is located.

2.1.4.2.

Text was deleted. It is not necessary for a client to re-sign an original application if less than a calendar month has passed since a client's eligibility has been terminated.

NEW TEXT

If less than a calendar month has passed since a client's eligibility has been terminated and the client is not open for any other program, the client can provide the necessary information to reopen his/her MA without filing a new application. ~~and re-sign the original application or page one of the CAF.~~

3.6.6

New text was added clarifying disability re-determinations for individuals over 65.

New Text

Note: Disability determinations should not be done for recipients over age 65, except in some circumstances for MAPP (See 3.6.9.1 for MAPP)

3.6.8.1.3

Clarification was provided in the Presumptive Disability Section that the Medicaid Disability Application (HCF 10112) must be completed prior to the IM worker certifying a client for PD.

New Text:

Note: Whether the IM worker makes the PD determination or DDB makes the PD determination, the Medicaid Disability Application (HCF 10112) must be completed "before" the IM worker certifies the client for PD.

3.6.9.1

Text was included in the MAPP section clarifying that a disability re-determination was not needed until the next scheduled diary date for an individual who lost OASDI benefits solely because s/he turned 65.

New Text

Note: MAPP recipients who lose their OASDI benefits solely because s/he turns 65 do not need a disability re-determination until the next scheduled diary date. If there is no scheduled diary date a MAPP disability determination must be done.

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4.1.4.1 The change in the trust policy made in the January 11, 2005, 05-01 release, regarding third party vendor payments has been rescinded. Retroactive to January 11, 2005 trust policy is as follows:

New Text

All payments (including interest and dividends) from a trust to the beneficiary are unearned income to the beneficiary. See 4.1.4.9 for instructions on counting interest.

Do not count payments made from a trust to a third party on behalf of the trust beneficiary as income. This change was originally communicated in Operations Memo 05-13.

4.2.3.1.1 A note and link was placed in the EBD asset section to highlight that business property is not the only possible type of property subject to an asset exclusion.

4.7.4 The section on when an institutionalized person or his/her spouse can divest homestead property to his/her child without penalty was re-organized to clarify policy.

4.7.5 On January 1, 2005, the average nursing home private pay rate increased to $5096. The text and examples were updated to reflect the increased average nursing home private pay rate. This was originally communicated in Operations Memo 05-09.

4.8.1 Clarification and two examples were provided for a child with budgeted income in FFU testing.

4.8.4, 5.16.7
5.16.8, 5.16.9, 8.1.6 The Federal Poverty Level increased effective March 1, 2005. Tables and examples were updated to reflect the increase in income limits. This was originally communicated in Operations Memo 05-10.

4.9.8.1.1 e. A definition for supportive home care was placed in the handbook.

New Text:

Supportive home care is necessary assistance to help people meet their daily living needs, ensure adequate functioning in their home, and safely access their community. Services may include:

1. **Assistance with activities of daily living.**
2. **Attendant care.**
3. **Supervision.**
4. **Reporting changes in the participant's condition,**
5. **Assistance with medication and medical procedures which are normally self-administered, or**
6. **The extension of therapy services, ambulation and exercise.**
7. **Tasks associated with routine household upkeep including; general housekeeping chores, lawn mowing, snow removal, changing storm or screen windows and other household services that are essential to the participant's safety, well-being and care at home.**

5.7.3 The non-financial requirements sub-chapter for BadgerCare was modified to incorporate verification requirements (for earnings and employer provided health insurance) originally communicated in Operations Memos 04-22, and 04-59.

5.7.3.4.3 Clarification was provided in the good cause section.

New Text

If you have an unusual situation where coverage **(either employer provided insurance or other private health insurance)** ended in the last three months for a reason beyond the control of the family, contact the CARES Call Center

5.8.7.4.2 New text and an example were added to clarify patient liability when a client or applicant moves from a hospital to a nursing home.

5.8.11 Milwaukee County Mental Health Complex certification as an Institution for Mental Disease (IMD) ended 09/01/04. Milwaukee County Mental Health Complex became certified as a Skill Nursing Facility (SNF) 09/01/04.

5.11.2 A clarification was provided that a parent's railroad retirement income does not qualify as an OASDI payment for DAC.

5.12.10 HEC regional screeners were updated.

5.13.7 Clarification was provided to the Family Care closure policy.

New Text:

If a FC case closes for any reason and **a re-determination is allowed (see 2.1.4.2.1 Termination)** without a new application**,** contact the CMO to determine if the client has been served continuously by the CMO **beyond the effective date of ineligibility or disenrollment**. Note in case comments any information from the CMO **that verifies continuous service.**

If the client has been served continuously by the CMO, a new enrollment form **is not needed.** If a disenrollment date exists on ANFR, begin another segment with a start date for the day following the disenrollment date.

If the client has not been served continuously by the CMO**, or a period of ineligibility greater than 30 days has occurred,** a new enrollment form signed by the client and **new** enrollment date are required**. The IM worker should obtain the form and date from the Resource Center.**

Example 1: Sam's Family Care eligibility ended on December 31st, due to lack of review. The CMO continues to provide services in January while Sam completes his review.

A new enrollment form is not required. Sam's review is completed, he meets all eligibility requirements, and eligibility is determined prior to January 31st. A new enrollment date of January 1st must be entered in ANFR.

Example 2: Tillie lost her Family Care eligibility on November 30th, due to having assets over the program limits. The CMO stopped serving her on December 1st. On January 15th, Tillie contacts the Resource Center and tells them that she reduced her assets. Since she became ineligible more than 30 days ago Tillie must complete a new application and a new enrollment date must be set.

5.16.3.1.1 Clarification and three examples were provided on possible eligibility for a refund of the SC enrollment fee**.**

New Text

SC prescription drug benefits include use of the SC card to receive discounted drug prices in levels 1, 2a, and 2b. A re-

fund may be issued if such charges are reversed by the pharmacy.

Use of the SC card at Level 3 where a spend-down has not been met constitutes receipt of SC prescription drug services. A refund may be issued if such claims are reversed by the pharmacy.

Example 1: Henry was a SC participant at Level 1 whose benefit period began 12/01/04. Henry passed away on 12/04/04. His daughter reported Henry's death to the SC program on 12/10/04 and requested a refund of his $30 enrollment fee. Henry's SC card had been used on 12/01/04 to purchase a prescription, however the pharmacy had reversed those charges on 12/05/04 since Henry's prescription had not been picked up. The $30 enrollment fee should refunded in this case since Henry did not receive any SC prescription drug benefits or services.

Example 2: Julie is a SC participant at Level 2b. Julie's SC application filing date was 10/26/04 and her benefit period began 11/01/04. On 11/15/04 Julie calls SeniorCare Customer Service Hotline to withdraw from the SC program and request a refund of her $30 enrollment fee. Julie used her SC card on 11/10/04 when she purchased a prescription. Although Julie requested a refund within 30 days of her application filing date, she is not entitled to a refund, because she received her prescription at a discounted cost by using her SC card.

Example 3: Mike is a Level 3 SC participant. Mike's SC application filing date was 10/28/04 and his benefit period began 11/01/04. On 11/20/04, Mike requests to withdraw from the SC program and that his $30 enrollment fee be refunded to him. Mike used his SC card on 11/18/04 when he purchased a prescription, however, he had not met his Level 3 spenddown, so he did not receive a discounted price for his prescription. Mike is entitled to a refund of his enrollment fee if the pharmacy reverses these prescription claims because he made the request within 30 days of his application filing date and he has not received any SC prescription drug benefits or services. If the claims are not reversed, Mike is not entitled to a refund.

5.16.3.1.2 New SeniorCare policy on requests for refunds was placed in the handbook. Effective November 1, 2004, requests for a refund on behalf of a deceased participant must be made within 45 days of the date of death rather than 10 days.

New Text:

Refunds to Deceased Participants:

A refund may also be requested by the family member of a deceased participant, when all the following criteria are met:

1. S/he received an eligibility notification.
2. Death occurs prior to the start of or within 30 days of the beginning of the SC benefit period, and
3. The request is made within ~~10~~ **45** days of the date of death, and
4. S/he had not received any SC prescription drug benefits or services.

5.16.5.2 Clarification and an example was provided in the eligibility begin date section of SeniorCare on how to address agency errors.

New Text

If a gap in coverage of not more than one month occurs due to an agency error, eligibility for a new 12-month benefit period begins the first of the month the completed application is received and all eligibility requirements are met, including payment of the annual enrollment fee.

Example: Harold's PPRA was mailed to him on December 13th to be completed for his new benefit period, that begins February 1st. The PPRA was mailed to the last known address in CARES which belonged to Harold's wife Mary who was in a nursing home. Mary passed away on May 2nd of this year and although the local agency worker ended her Medicaid eligibility, the case address was not updated in CARES. Harold has not moved, so he was not required to report a change of address to the SC program. Due to the incorrect address, Harold did not receive the PPRA form to complete until late in January. The completed PPRA was received by the SC program on February 10th along with a letter explaining why it was late. Harold's new SC benefit period is February 1st through January 31st since the one month gap in coverage was due to an agency error.

5.16.10.1.1 Clarification was provided for SeniorCare agency errors. Agency errors for overpayment or underpayment will be corrected back to

initial eligibility date of the **current** benefit period.

New Text

Agency errors for SC will be determined on a case by case basis. If the error resulted in an overpayment, past benefits are not recoverable. If the error resulted in an underpayment, corrected benefits will be restored back to initial eligibility date of the **current** benefit period.

5.17.2.1 New text was included in the Wisconsin Well Woman Medicaid to clarify what constitutes disqualifying insurance coverage.

New Text

A woman is ineligible for Wisconsin Well Woman Medicaid if she is covered by any one of the following:

1. Group health plans.

2. **Full benefit** health insurance.

3. Medicare Parts A or B.

4. Any other category of **full benefit** MA.

5. Veteran's benefits/CHAMPUS.

6. HIRSP.

7. Federal employee health plans.

8. Peace Corps health plans.

9. Other **full benefit** private or public health care **plans that provide cancer treatment.**

5.17.7.1 A new sub-section on inter- agency transfers for Wisconsin Well Woman participants was added.

6.2.2.2.3 A new example was placed in the handbook to clarify overpayment policy for BC cases where the client underpaid premiums. The overpayment amount is the difference between the premium paid and the premium owed even if the premium that was paid was $0.

7.1.4.1	Clarification was provided that parking fees are not reimbursable as a "related travel expense."

Minor Edits

3.6.8.2,.3.1.9.1	References and links to the HFS-9 were replaced with links to the HCF 14014.
5.4.7.3	A link and reference was added to voluntary exclusions in AFDC MA.
5.4.11	A typo was corrected in the assistance standard. The corrected amount for a group size of two is $533.
8.1.3	Grant county was added to region 2 in the County and Tribal region table in 8.1.3. It was inadvertently removed from the list in the 04-03 release.
8.1.5	The EBD Deeming amount to an ineligible minor was corrected to $290, it was formerly listed as $289.50.
8.3.1	The link to the alphabetical and numerical listing to DHFS forms was updated to the new Income Maintenance Forms Page at http://dhfs.wisconsin.gov/em/forms/imforms.htm .